Case Number:	CM14-0016941		
Date Assigned:	03/07/2014	**Date of Injury:**	11/20/2000
Decision Date:	04/14/2014	**UR Denial Date:**	01/21/2014
Priority:	Standard	**Application Received:**	02/10/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Internal Medicine, and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Physician Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 54 yo male who sustained a work related injury on 11/20/2000. The mechanism of injury was not provided. His diagnoses include chronic low back pain, bilateral shoulde r pain, ankle and knee pain. He complains of 7-8/10 low back pain which is constant, sharp, and aching and is worsened by sitting and standing. On exam there is decreased range of motion at the lumbar spine. Straight leg raising is positive on the left. Treatment includes medical therapy with opiates, epidural steroid injection therapy and H-wave therapy. The treating provider has requested Roxicodone 30mg # 150, Avinza 120mg # 30, Wellbutrin XL 300mg #30, Zofran 8mg # 30, and Flexeril 10mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

ROXICODONE 30 MG #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the employee has been treated with opioid therapy with Roxicodone and Avinza for pain control. According to the MTUS Guidelines,

short-acting opioids such as Roxicodone are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last asessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that the employee has responded to ongoing opioid therapy. According to the MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this employee. The employee has continued pain despite the use of long and short acting opioid medications. Medical necessity for Roxicodone has not been established. The requested treatment is not medically necessary.

AVINZA 120MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation inidicates the employee has been treated with opioid therapy with Avinza and Roxicodone for pain control. According to the MTUS Guidelines, extended-relaease opioids such as Avinza are seen as an effective method in controlling chronic pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last asessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that the employee has responded to ongoing opioid therapy. According to the MTUS Guidelines, there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this employee. The employee has continued pain despite the use of long and short acting opioid medications. Medical necessity for Avinza 120mg has not been established. The requested treatment is not medically necessary.

WELLBUTRIN XL 300MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27.

Decision rationale: There is no documentation provided necessitating therapy with Wellbutrin. The reviewed guidelines indicate that while bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non-neuropathic chronic low back pain. Furthermore, bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

ZOFRAN 8MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation US Food and Drug Administration website: Ondansetron.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2012: Zofran Indications.

Decision rationale: Ondansetron, originally marketed under the brand name, Zofran, is a seritonin 5HT-3 receptor antagonist used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. The FDA indicates the medication is used for prevention of nausea and vomiting caused by cancer chemotherapy. There is no documentation provided necessitating the use of Zofran. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

FLEXERIL 10MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: According to the reviewed literature, Flexeril (Cyclobenzaprine) is not recommended for the long-term treatment of low back pain. The medication has its greatest effect in the first four days of treatment. The documentaiton indicates there are no palpable muscle spasms and there is no documentaiton of functional improvemment from any previous use of this medication. According to the MTUS Guidelines, muscle relxants are not considered any more effective than nonsteroidal anti-inflmmatory medications alone. Based on the currently available information, the medical necessity for this muscle relxant medication has not been established. The requested treatment is not medically necessary.